

 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.** This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 866-843-3461 or visit us at [www.healthpartners.com](http://www.healthpartners.com). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 866-843-3461 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	In-network: \$1,500 Individual/ \$3,000 Family Out-of-network: \$10,000 Individual/ \$20,000 Family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes, some preventive care services are covered before you meet your deductible.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain preventive services without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	There are no other specific <a href="#">deductibles</a> .	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	In-network medical/pharmacy: \$6,500 Individual/\$13,000 Family Out-of-network medical/pharmacy: \$30,000 Individual/\$60,000 Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.

Important Questions	Answers	Why This Matters:
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premium</a> , balance-billed charges (unless <a href="#">balanced billing</a> is prohibited), and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.healthpartnersunitypoint.com/bridges">www.healthpartnersunitypoint.com/bridges</a> or call 1-866-843-3461 for a list of <a href="#">in-network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the in-network <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, and Other Important Information
		<a href="#">Network Provider</a> (You will pay the least)	<a href="#">Out-of-Network Provider</a> (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	Primary Office Visit: \$30 <a href="#">copay</a> /Per Visit, <a href="#">Deductible</a> does not apply Convenience Care: \$15 <a href="#">copay</a> /Per Visit, <a href="#">Deductible</a> does not apply UnityPoint Health Virtual Care or Virtuwell: No charge	Primary Office Visit: 50% <a href="#">coinsurance</a> Convenience Care: 50% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$60 <a href="#">copay</a> /Per Visit, <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	50% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
	<a href="#">Diagnostic test</a> (x-ray, blood	30% <a href="#">coinsurance</a> for	50% <a href="#">coinsurance</a>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, and Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	work)	x-ray/No charge for lab		
	Imaging (CT/PET scans, MRIs)	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://healthpartners.com/genericsadvantagerx">healthpartners.com/genericsadvantagerx</a>	Generic drugs	<a href="#">Formulary</a> : \$15 <a href="#">copay</a> /Per Prescription, <a href="#">Deductible</a> does not apply at retail, \$45 <a href="#">copay</a> , <a href="#">Deductible</a> does not apply at mail <a href="#">Non-formulary</a> : \$100 <a href="#">copay</a> /Per Prescription, <a href="#">Deductible</a> does not apply \$300 <a href="#">copay</a> , <a href="#">Deductible</a> does not apply at mail	<a href="#">Formulary</a> : 50% <a href="#">coinsurance</a> at retail, mail not covered <a href="#">Non-formulary</a> : 50% <a href="#">coinsurance</a> at retail, mail not covered	31 day supply retail / 93 day supply mail order. Formulary insulin covered with no member cost-sharing after a \$25 benefit cap per prescription per month.
	Formulary brand drugs	\$50 <a href="#">copay</a> /Per Prescription, <a href="#">Deductible</a> does not apply at retail, \$150 <a href="#">copay</a> , <a href="#">Deductible</a> does not apply at mail	50% <a href="#">coinsurance</a> at retail, mail not covered	
	Non-formulary brand drugs	\$100 <a href="#">copay</a> /Per Prescription, <a href="#">Deductible</a> does not apply at retail, \$300 <a href="#">copay</a> , <a href="#">Deductible</a> does not apply at mail	50% <a href="#">coinsurance</a> at retail, mail not covered	
	<a href="#">Specialty drugs</a>	20% <a href="#">coinsurance</a> , <a href="#">Deductible</a> does not apply	Not covered	Specialty drugs are limited to drugs on the specialty drug list and must be obtained from a designated vendor. \$300 maximum copay per prescription per month.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, and Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Out-of-network services apply to the in-network deductible.
	<a href="#">Emergency medical transportation</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Out-of-network services apply to the in-network deductible.
	<a href="#">Urgent care</a>	\$60 <a href="#">copay</a> /Per Visit, <a href="#">Deductible</a> does not apply	\$60 <a href="#">copay</a> /Per Visit, <a href="#">Deductible</a> does not apply	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
If you need mental health, behavioral health, or substance abuse needs	Outpatient services	\$30 <a href="#">copay</a> /Per Visit, <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a>	
	Inpatient services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
If you are pregnant	Office visits	No charge	50% <a href="#">coinsurance</a>	Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	Childbirth/delivery facility services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	\$30 <a href="#">copay</a> /Per Visit, <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a>	None
	<a href="#">Rehabilitation services</a>	\$30 <a href="#">copay</a> /Per Visit, <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a>	None
	<a href="#">Habilitation services</a>	\$30 <a href="#">copay</a> /Per Visit, <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a>	None
	<a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, and Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<a href="#">Durable medical equipment</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	<a href="#">Hospice services</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	15 days per lifetime .
If your child needs dental or eye care	Children's eye exam	No charge	50% <a href="#">coinsurance</a>	None
	Children's glasses	30% <a href="#">coinsurance</a>	Not covered	Limited to one pair of eyeglasses (lenses and frames) or one pair of contact lenses per benefit year.
	Children's dental check-up	No charge	No charge	None

### Excluded Services & Other Covered Services:

#### Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other [excluded services](#).)

- Acupuncture
- Cosmetic surgery with the exception of port wine stain removal and reconstructive surgery
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

#### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Bariatric surgery
- Chiropractic care
- Dental care (Children)
- Private-duty nursing
- Routine eye care (Adult)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Your plan at 1-866-843-3461, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), Iowa Insurance Division at 1-515-281-6348. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Your [plan](#) at 1-866-843-3461, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or the Iowa Insurance Division at 1-515-281-6348.

**Does this plan provide Minimum Essential Coverage? Yes.**

[Minimum Essential Coverage](#) generally includes [plan](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet Minimum Value Standards? Yes.**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-398-9119.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-843-3461.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-866-843-3461.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-843-3461.

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*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,500	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,500	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,500
■ <a href="#">Specialist coinsurance</a>	20%	■ <a href="#">Specialist coinsurance</a>	20%	■ <a href="#">Specialist coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%	■ Hospital (facility) <a href="#">coinsurance</a>	20%	■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%	■ Other <a href="#">coinsurance</a>	20%	■ Other <a href="#">coinsurance</a>	20%
<p>This EXAMPLE event includes services like:  <a href="#">Specialist</a> office visits (<i>prenatal care</i>)                      Childbirth/Delivery Professional Services                      Childbirth/Delivery Facility Services  <a href="#">Diagnostic tests</a> (<i>ultrasounds and blood work</i>)  <a href="#">Specialist</a> visit (<i>anesthesia</i>)</p>		<p>This EXAMPLE event includes services like:  <a href="#">Primary care physician</a> office visits (<i>including disease education</i>)  <a href="#">Diagnostic tests</a> (<i>blood work</i>)  <a href="#">Prescription drugs</a>  <a href="#">Durable medical equipment</a> (<i>glucose meter</i>)</p>		<p>This EXAMPLE event includes services like:  <a href="#">Emergency room care</a> (<i>including medical supplies</i>)  <a href="#">Diagnostic test</a> (<i>x-ray</i>)  <a href="#">Durable medical equipment</a> (<i>crutches</i>)  <a href="#">Rehabilitation services</a> (<i>physical therapy</i>)</p>	
<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,800</b>
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,500	<a href="#">Deductibles*</a>	\$1,500	<a href="#">Deductibles*</a>	\$1,500
<a href="#">Copayments</a>	\$0	<a href="#">Copayments</a>	\$300	<a href="#">Copayments</a>	\$100
<a href="#">Coinsurance</a>	\$2,200	<a href="#">Coinsurance</a>	\$90	<a href="#">Coinsurance</a>	\$200
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$70	Limits or exclusions	\$20	Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$3,770</b>	<b>The total Joe would pay is</b>	<b>\$1,910</b>	<b>The total Mia would pay is</b>	<b>\$1,800</b>